Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000772 06/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SOUTH FINLEY ROAD **BEACON HILL** LOMBARD, IL 60148 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 **Annual Certification Survey** Complaint Investigation 1673120/IL86054 S9999 Final Observations S9999 Statement of Licensure Violations 300.1210 b) 5) 300.1210 d) 6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following Attachment A and shall be practiced on a 24-hour. seven-day-a-week basis: **Statement of Licensure Violations** 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/27/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	that each resident rand assistance to p These requirements Based on observati review the facility fa policy while assistin failed to assess the resident off the floor This applies to 1 of for falls in the samp The findings include	on, interview and record iled to follow its own transfer g a resident to the toilet and resident prior to lifting the r. 3 residents (R101) reviewed le of 3.			
	According to the EHR (Electronic Health Record) R101 has diagnoses including osteoarthritis,				
	dementia, muscle wand Alzheimer's discand Physical Exami 2011 shows R101 h knee replacement whee and right hip fradmission. The MDS May 23, 2016 shows incontinent of urine, two staff members frassistance of two stacare plan dated Marneeded assistance of mechanical lift transion. On June 8, 2016 at fall on June 2, 2016 Nursing Assistant) w	reakness, anxiety disorder case. An Admission History nation dated November 30, ad a surgical history of left with a healed scar on the left acture 10 years prior to 6 (Minimum Data Set) dated is R101 was frequently needed total assistance of or transfers and extensive aff members for toilet use. A ch 2, 2016 shows R101 of two staff members for			
	On June 8, 2016 at trequested to urgently	5:00pm E11 stated R101 had vuse the toilet on June 2,			

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mechanical lift would not fit into the bathroom. R101 had a gait belt applied around the waist and then draw sheets were used to lift R101 from the floor directly to the motorized wheelchair. E10 said she didn't do a physical assessment with skin check on R101 until R101 was seated in the

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